NEUROVASCULAR STROKE RECEIVING CENTERS CRITERIA AND DESTINATION POLICY

(San Bernardino County Only)

I. PURPOSE

To provide developing guidelines to rapidly transport stroke patients who access the 9-1-1 system to a designated Neurovascular Stroke Receiving Center (NSRC) when indicated. Patients transported to NSRC will benefit from rapid assessment, intervention and treatment at a dedicated stroke specialty center. Patients will meet the defined criteria for triage as an acute ischemic or hemorrhagic cerebral vascular event.

II. DEFINITIONS

Interventional Neuroradiologic Capabilities: A licensed general acute care hospital with qualified interventional radiologists and/or neurosurgeons able to administer inter-arterial tissue plasminogen activator and/or perform mechanical clot retrieval.

mLAPSS: Modified Los Angeles County Prehospital Stroke Screening Scale.

Neurovascular Stroke Base Hospital: A licensed general acute care hospital that has The Joint Commission (TJC) or Healthcare Facilities Accreditation Program (HFAP) Primary Stroke Center accreditation and designated as a base hospital.

Neurovascular Stroke Receiving Centers (NSRC): A twenty-four (24) hours per day, seven (7) days per week licensed general acute care hospital that has successfully completed and maintains TJC or HFAP accreditation as a Primary Stroke Center and enters into an agreement with ICEMA, for patients triaged as having a cerebral vascular event requiring hospitalization for treatment, evaluation and/or management of this event.

Neurovascular Stroke Referral Hospital (NSRH): A licensed general acute care hospital that refers possible stroke patients to NSRC.

III. POLICY

The following requirements must be met for a hospital to be an ICEMA designated NSRC:

- An ICEMA approved receiving hospital which is a full service acute care hospital.
- Accreditation as a Primary Stroke Center by TJC or HFAP and proof of re-accreditation every two (2) years.

- An alert/communication system for notification of incoming stroke patients, available twenty-four (24) hours per day, seven (7) days per week (i.e., in-house paging system).

- Provide continuing education (CE) opportunities twice per year for NSRC, NSRH and emergency medical services (EMS) field personnel in areas of pathophysiology, assessment, triage and management for stroke patients and report annually to ICEMA.

- Lead public stroke education efforts at the appropriate educational level and report annually to ICEMA.

IV. STAFFING REQUIREMENTS

The hospital will have the following positions filled prior to becoming a NSRC:

- Medical Directors

  The hospital shall designate two (2) physicians with hospital privileges as co-directors of its NSRC program. One (1) physician shall be board certified or board eligible by the American Board of Medical Specialties or American Osteopathic Association, neurology or neurosurgery board. The co-director shall be a board certified or board eligible emergency medicine physician.

- Nursing Coordinator

  The hospital shall designate a NSRC Nursing Coordinator who has experience in critical care or emergency nursing, and has advanced education in stroke physiology or at least has two (2) years dedicated stroke patient management experience. Certification in critical care or emergency nursing is preferred.

- On-Call Physicians Specialists/Consultants

  A daily roster of the following on-call physician consultants and staff must be promptly available within thirty (30) minutes of notification of "Stroke Alert" twenty-four (24) hours per day, seven (7) days per week.

  - Radiologist experienced in neuroradiologic interpretations.

  - On-call Neurologist and /or tele-neurology services available twenty-four (24) hours per day; seven (7) days per week.

  - If neurosurgical services are not available in-house, the hospital must have a rapid transfer agreement in place with a hospital that provides this service. The agreement must be on file with the ICEMA.

NSRCs must promptly accept rapid transfer requests from NSRCs. Additionally, the hospital must have a rapid transport agreement in place with an ICEMA permitted transport provider for that exclusive operation area (EOA).

V. INTERNAL HOSPITAL POLICIES

The hospital shall develop internal policies for the following situations:

- Stroke Team alert response policy upon EMS notification of a "Stroke Alert".
- Rapid assessment of stroke patient by Emergency and Neurology Teams.
- Prioritization of ancillary services including laboratory and pharmacy with notification of "Stroke Alert".
- Arrangement for priority bed availability in Acute Stroke Unit or Intensive Care Unit (ICU) for "Stroke Alert" patients.
- Acknowledgement that stroke patients may **only** be diverted during the times of Internal Disaster in accordance to ICEMA Reference #8060 - Requests for Hospital Diversion Policy (applies to physical plant breakdown threatening significant patient services or immediate patient safety issues, i.e., bomb threat, earthquake damage, hazardous material or safety and security of the hospital.) A written notification describing the event must be submitted to ICEMA within twenty-four (24) hours.
- Emergent thrombolytic and tele-neurology (if waiver is approved) protocol to be used by Neurology, Emergency, Pharmacy and Critical Care Teams.
- Readiness of diagnostic computed tomography (CT) and magnetic resonance imaging (MRI), upon notification of Stroke Team.

VI. DATA COLLECTION

Data will be reported to the ICEMA Medical Director on a monthly basis using an ICEMA approved registry.

VII. CONTINUOUS QUALITY IMPROVEMENT PROGRAM

NSRC shall develop an on-going CQI program which monitors all aspects of treatment and management of stroke patients and identify areas needing improvement. The program must, at a minimum, monitor the following parameters:

- Morbidity and mortality related to procedural complications.

- Tracking door-to-intervention times and adherence to minimum performance standards.

  ICEMA will determine current performance indicators. Any specific or additional performance indicators will be determined in collaboration with the Stroke CQI Committee.

- Active participation in ICEMA Stroke CQI Committee activities.

VIII. PERFORMANCE STANDARDS

Compliance with the American Stroke Association Performance Measures as a Primary Stroke Center.

IX. DESIGNATION

- The NSRC applicant shall be designated by ICEMA after satisfactory review of written documentation, a potential site survey and completion of an agreement between the hospital and ICEMA.

- Documentation of current accreditation as a Primary Stroke Center by TJC or HFAP shall be accepted in lieu of a formal site visit by ICEMA.

- Initial designation as a NSRC shall be in accordance with terms outlined in the agreement.

- Failure to comply with the agreement, criteria and performance standards outlined in this policy may result in probation, suspension or rescission of the NSRC designation.

X. PATIENT DESTINATION

- The NSRC should be considered as the destination of choice if all of the following criteria are met:

  - Stroke patients eligible for transport to NSRC (suspected stroke patients) will be identified using the mLAPSS triage criteria.

  - Identified acute stroke patients with “last seen normal” time plus transport time equaling greater than twelve (12) hours, or if “last seen normal” time is unknown, transport to the closest receiving hospital.

  - Identified stroke patients with “last seen normal” time less than twelve (12) hours, or a “wake-up stroke”, transport to closest NSRC.

- NSRC base hospital contact is **mandatory** for all patients identified as a possible stroke patient.

- The NSRC base hospital is the only authority that can direct a patient to a NSRC. The destination may be changed at NSRC base hospital discretion.

- The NSRC base hospital, if different from the NSRC, will notify the NSRC of the patient's pending arrival as soon as possible, to allow timely notification of Stroke Team.

- The following factors should be considered in determining choice of destination for acute stroke patients. NSRC base hospital contact and consultation is mandatory in these situations:

  - Patients with unmanageable airway, unstable cardiopulmonary condition, or in cardiopulmonary arrest should be transported to the closest receiving hospital.

  - Patients with obvious contraindication to thrombolytic therapy should be strongly considered for transport to closest NSRC.

  - Patients with hemodynamic instability and exhibiting signs of inadequate tissue perfusion should be transported to the closest receiving hospital.

XI. REFERENCE

Number	**Name**
8060	Requests for Hospital Diversion Policy (San Bernardino County Only)